



Benefit Comparison – Plans Effective July 1, 2026

	MEA CHOICE PLUS PLAN		MEA CHOICE PLUS VALUE PLAN		MEA STANDARD PLAN		MEA STANDARD CORE PLAN		MEA STANDARD BASIC PLAN	
SERVICE	Higher Benefit Level	Out-of-Network	Higher Benefit Level	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Information	Coverage in this column applies to maximum allowances for covered services provided by a Blue Choice New England POS network provider or when Anthem approves an out-of-network referral for services provided by an out-of-network provider.	Coverage in this column applies to maximum allowances for covered services when you receive health care from providers or professionals who are not in the Blue Choice New England POS network.	Coverage in this column applies to maximum allowances for covered services provided by a Blue Choice New England POS network provider or when Anthem approves an out-of-network referral for services provided by an out-of-network provider.	Coverage in this column applies to maximum allowances for covered services when you receive health care from providers or professionals who are not in the Blue Choice New England POS network.	Coverage in this column applies to maximum allowances for covered services when you receive health care from providers or professionals in the Blue Choice PPO network.	Coverage in this column applies to maximum allowances for covered services when you receive health care from providers or professionals who are not in the Blue Choice PPO network.	Coverage in this column applies to maximum allowances for covered services when you receive health care from providers or professionals in the Blue Choice PPO network.	Coverage in this column applies to maximum allowances for covered services when you receive health care from providers or professionals who are not in the Blue Choice PPO network.	Coverage in this column applies to maximum allowances for covered services when you receive health care from providers or professionals in the Blue Choice PPO network.	Coverage in this column applies to maximum allowances for covered services when you receive health care from providers or professionals who are not in the Blue Choice PPO network.
Network	Blue Choice New England POS		Blue Choice New England POS		Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)	
Primary Care Physician Required	YES		YES		NO		NO		NO	
Physician Office Visits Sick Care	\$0 for the first visit and then \$20 PCP copay 100% after \$30 Specialist copay	60% after deductible	\$0 for the first visit and then \$25 PCP copay 100% after \$35 Specialist copay	55% after deductible	\$0 for the first visit and then \$20 PCP copay 100% after \$30 Specialist copay	60% after deductible 60% after-deductible	\$0 for the first visit and then \$25 PCP copay 100% after \$35 Specialist copay	55% after deductible 55% after-deductible	\$0 for the first visit and then \$25 PCP copay 100% after \$35 Specialist copay	55% after deductible 55% after-deductible
Preventive & Well Care Services	100%	Not Covered	100%	Not Covered	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Calendar Year Deductible	\$300 per person \$600 per family	\$350 per person \$700 per family	\$2,500 per person \$5,000 per family	\$5,000 per person \$10,000 per family	\$300 per person \$600 per family		\$600 per person \$1,200 per family		\$1,100 per person \$2,200 per family	
Coinsurance Limit	\$1,500 per person \$3,000 per family	\$2,750 per person \$5,500 per family	\$2,500 per person \$5,000 per family	\$5,000 per person \$10,000 per family	\$1,500 per person \$3,000 per family		\$2,500 per person \$5,000 per family		\$2,500 per person \$5,000 per family	
Out of Pocket (Deductible + Coinsurance)	\$1,800 per person \$3,600 per family	\$3,100 per person \$6,200 per family	\$5,000 per person \$10,000 per family	\$10,000 per person \$20,000 per family	\$1,800 per person \$3,600 per family		\$3,100 per person \$6,200 per family		\$3,600 per person \$7,200 per family	
Total Calendar Year Out-of-Pocket (Deductible + Coinsurance + Copays)	\$10,600 per person \$21,200 per family	\$10,600 per person \$21,200 per family	\$10,600 per person \$21,200 per family	\$14,200 per person \$28,400 per family	\$10,600 per person \$21,200 per family		\$10,600 per person \$21,200 per family		\$10,600 per person \$21,200 per family	



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SERVICE	Higher Benefit Level	Out-of-Network	Higher Benefit Level	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Utilization Management	All inpatient admissions, except emergency and maternity admissions are subject to preadmission authorization by your Primary Care Physician.	All inpatient admissions, except emergency and maternity admissions are subject to preadmission authorization. You, your physician or the provider must call Anthem Medical Management at 1-800-392-1016.	All inpatient admissions, except emergency and maternity admissions are subject to preadmission authorization by your Primary Care Physician.	All inpatient admissions, except emergency and maternity admissions are subject to preadmission authorization. You, your physician or the provider must call Anthem Medical Management at 1-800-392-1016.	All inpatient admissions, except emergency and maternity admissions are subject to preadmission authorization. You, your physician or the provider must call Anthem Medical Management at 1-800-392-1016.		All inpatient admissions, except emergency and maternity admissions, are subject to preadmission authorization. You, your physician or the provider must call Anthem Medical Management at 1-800-392-1016.		All inpatient admissions, except emergency and maternity admissions are subject to preadmission authorization. You, your physician or the provider must call Anthem Medical Management at 1-800-392-1016.	
Hospital Services Inpatient Outpatient Emergency Care in ER	80% after deductible 80% after deductible 80% after deductible	60% after deductible 60% after deductible 80% after deductible	75% after deductible 75% after deductible 75% after deductible	55% after deductible 55% after deductible 75% after deductible	80% after deductible 80% after deductible 80% after deductible	60% after deductible 60% after deductible 60% after deductible	75% after deductible 75% after deductible 75% after deductible	55% after deductible 55% after deductible 75% after deductible	75% after deductible 75% after deductible 75% after deductible	55% after deductible 55% after deductible 75% after deductible
Walk In Center	100% after \$20 PCP copay	60% after deductible	100% after \$25 PCP copay	55% after deductible	100% after \$20 PCP copay	60% after deductible	100% after \$25 PCP copay	55% after deductible	100% after \$25 PCP copay	55% after deductible
LiveHealth Online (Preferred On-line visits)	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$0 copay	NA	\$0 copay	NA	\$0 copay	NA
Behavioral Health	No Charge	No Charge	No Charge	No Charge	No Charge	NA	No Charge	NA	No Charge	NA
Ambulance	80% after deductible		75% after deductible		80% after deductible		75% after deductible		75% after deductible	
Professional Services Inpatient Outpatient Diagnostic Tests Outpatient Surgery Maternity	80% after deductible 80% after deductible 80% after deductible 80% after deductible	60% after deductible 60% after deductible 60% after deductible 60% after deductible	75% after deductible 75% after deductible 75% after deductible 75% after deductible	55% after deductible 55% after deductible 55% after deductible 55% after deductible	80% after deductible 80% after deductible 80% after deductible 80% after deductible	60% after deductible 60% after deductible 60% after deductible 60% after deductible	75% after deductible 75% after deductible 75% after deductible 75% after deductible	55% after deductible 55% after deductible 55% after deductible 55% after deductible	75% after deductible 75% after deductible 75% after deductible 75% after deductible	55% after deductible 55% after deductible 55% after deductible 55% after deductible
Advanced Diagnostic Imaging for example: MRI, PET and CAT scans. These services require prior authorization	80% after deductible	60% after deductible	75% after deductible	55% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible
Occupational Therapy, Physical Therapy, and Speech Therapy	80% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation No Annual Limit	60% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation No Annual Limit	75% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation No Annual Limit	55% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation No Annual Limit	80% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation 60 visits per member per calendar year for all therapies combined	60% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation 60 visits per member per calendar year for all therapies combined	75% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation 60 visits per member per calendar year for all therapies combined	55% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation 60 visits per member per calendar year for all therapies combined	75% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation 60 visits per member per calendar year for all therapies combined	55% after deductible Office visit copay will apply to OT/PT evaluation or re-evaluation 60 visits per member per calendar year for all therapies combined



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SERVICE	Higher Benefit Level	Out-of-Network	Higher Benefit Level	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Chiropractic Care – Physical Manipulations	80% after deductible No Annual Limit	60% after deductible No Annual Limit	75% after deductible No Annual Limit	55% after deductible No Annual Limit	80% after deductible No Annual Limit	60% after deductible No Annual Limit	75% after deductible No Annual Limit	55% after deductible No Annual Limit	75% after deductible No Annual Limit	55% after deductible No Annual Limit
Nutritional Counseling	100%	60% after deductible	100%	55% no deductible	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Smoking Cessation Education Programs										
Physician Follow-up Visits	100%	60% after deductible	100%	55% after deductible	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Prescribed Medications (see list of select medications)	100%	60% after deductible	100%	55% after deductible	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Prescribed Medications (see list of select medications)	100%	Prescription drug copay applies	100%	Prescription drug copay applies	100%	Prescription drug copay applies	100%	Prescription drug copay applies	100%	Prescription drug copay applies
Inpatient Rehab/Skilled Nursing Facility	80% after deductible Up to 150 days per member per calendar year	60% after deductible Up to 150 days per member per calendar year	75% after deductible Up to 150 days per member per calendar year	55% after deductible Up to 150 days per member per calendar year	80% after deductible Up to 150 days per member per calendar year	60% after deductible Up to 150 days per member per calendar year	75% after deductible Up to 150 days per member per calendar year	55% after deductible Up to 150 days per member per calendar year	75% after deductible Up to 150 days per member per calendar year	55% after deductible Up to 150 days per member per calendar year
Home Health Care	80% after deductible	60% after deductible	75% after deductible	55% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible
Hospice	100%	60% no deductible	100%	55% no deductible	100%	80% no deductible	100%	80% no deductible	100%	80% no deductible
Acupuncture	80% after deductible	80% after deductible	75% after deductible	75% after deductible	80% after deductible Limited to 20 visits per year	60% after deductible Limited to 20 visits per year	75% after deductible Limited to 20 visits per year	55% after deductible Limited to 20 visits per year	75% after deductible Limited to 20 visits per year	55% after deductible Limited to 20 visits per year
Durable Medical Equipment	80% after deductible	60% after deductible	75% after deductible	55% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible
TMJ Services	80% after deductible	60% after deductible	75% after deductible	55% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible
Hearing Aids Children 1 per hearing impaired ear every 36 months. Adults limited to \$3,000 per hearing impaired ear every 36 months	80% after deductible	60% after deductible	75% after deductible	55% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible
Pediatric Dental Varnish	100% up to age 5	Not Covered	100% up to age 5	Not Covered	100% up to age 5	80% no deductible, up to age 5	100% up to age 5	80% no deductible, up to age 5	100% up to age 5	80% no deductible, up to age 5
Early Intervention Services (Limited for children up to age 36 months of age)	80% after deductible	60% after deductible	75% after deductible	55% after deductible	80% after deductible	60% after deductible	75% after deductible	55% after deductible	75% after deductible	55% after deductible



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SERVICE	Higher Benefit Level	Out-of-Network	Higher Benefit Level	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Autism Spectrum Disorders: Applied Behavior Analysis	100% after \$20 PCP copay	60% after deductible	100% after \$25 copay	55% after deductible	100% after \$20 copay	60% after deductible	100% after \$25 copay	55% after deductible	100% after \$25 copay	55% after deductible
BEHAVIORAL HEALTH Managed by Anthem Behavioral Health and all services require preauthorization. Failure to comply with the requirements outlined in your Certificate of Coverage may result in a reduced benefit.	Primary Care Physician referral is not required. This coverage level applies when the member obtains preauthorization from Anthem Behavioral Health at 1-800-755-0851, for all inpatient mental health and substance abuse services, and receives those services from the provider that the mental health care manager indicates.		Primary Care Physician referral is not required. This coverage level applies when the member obtains preauthorization from Anthem Behavioral Health at 1-800-755-0851, for all inpatient mental health and substance abuse services, and receives those services from the provider that the mental health care manager indicates.		This coverage level applies when the member obtains preauthorization from Anthem Behavioral Health at 1-800-755-0851, for all inpatient mental health and substance abuse services, and receives those services from the provider that the mental health care manager indicates.		This coverage level applies when the member obtains preauthorization from Anthem Behavioral Health at 1-800-755-0851, for all inpatient mental health and substance abuse services, and receives those services from the provider that the mental health care manager indicates.		This coverage level applies when the member obtains preauthorization from Anthem Behavioral Health at 1-800-755-0851, for all inpatient mental health and substance abuse services, and receives those services from the provider that the mental health care manager indicates.	
Behavioral Health Services										
Inpatient Residential Treatment Facility	80% after deductible 80% after deductible	60% after deductible 60% after deductible	75% after deductible 75% after deductible	55% after deductible 55% after deductible	80% after deductible 80% after deductible	60% after deductible 60% after deductible	75% after deductible 75% after deductible	55% after deductible 55% after deductible	75% after deductible 75% after deductible	55% after deductible 55% after deductible
Outpatient	80% (no deductible)	60% after deductible	75% (no deductible)	55% after deductible	80% (no deductible)	60% (no deductible)	75% (no deductible)	55% (no deductible)	75% (no deductible)	55% (no deductible)
Office Visits	No Charge	60% after deductible	No Charge	55% after deductible	No Charge	80% (no deductible)	No Charge	80% (no deductible)	No Charge	80% (no deductible)
Prescription Drug Coverage For each 30-day supply	Tier 1a: \$10 copay Tier 1b: \$20 copay Tier 2: \$45 copay Tier 3: \$70 copay Tier 4 Specialty: 20% coinsurance to \$150 (in-network only)		Tier 1a: \$10 copay Tier 1b: \$20 copay Tier 2: \$45 copay Tier 3: \$70 copay Tier 4 Specialty: 20% coinsurance to \$150 (in-network only)		Tier 1a: \$10 copay Tier 1b: \$20 copay Tier 2: \$45 copay Tier 3: \$70 copay Tier 4 Specialty: 20% coinsurance to \$150 (in-network only)		Tier 1a: \$10 copay Tier 1b: \$20 copay Tier 2: \$45 copay Tier 3: \$70 copay Tier 4 Specialty: 20% coinsurance to \$150 (in-network only)		Tier 1a: \$10 copay Tier 1b: \$20 copay Tier 2: \$45 copay Tier 3: \$70 copay Tier 4 Specialty: 20% coinsurance to \$150 (in-network only)	



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SERVICE	Higher Benefit Level	Out-of-Network	Higher Benefit Level	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mail Order and Select Retail Pharmacies for up to a 90-day supply (please ask your pharmacy if they offer this benefit)	Tier 1a: \$20 copay Tier 1b: \$40 copay Tier 2: \$90 copay Tier 3: \$140 copay Tier 4 Specialty: Not eligible for 90 day supply (in-network only)	Tier 1a: \$20 copay Tier 1b: \$40 copay Tier 2: \$90 copay Tier 3: \$140 copay Tier 4 Specialty: Not eligible for 90 day supply (in-network only)	Tier 1a: \$20 copay Tier 1b: \$40 copay Tier 2: \$90 copay Tier 3: \$140 copay Tier 4 Specialty: Not eligible for 90 day supply (in-network only)	Tier 1a: \$20 copay Tier 1b: \$40 copay Tier 2: \$90 copay Tier 3: \$140 copay Tier 4 Specialty: Not eligible for 90 day supply (in-network only)	Tier 1a: \$20 copay Tier 1b: \$40 copay Tier 2: \$90 copay Tier 3: \$140 copay Tier 4 Specialty: Not eligible for 90 day supply (in-network only)	Tier 1a: \$20 copay Tier 1b: \$40 copay Tier 2: \$90 copay Tier 3: \$140 copay Tier 4 Specialty: Not eligible for 90 day supply (in-network only)	Tier 1a: \$20 copay Tier 1b: \$40 copay Tier 2: \$90 copay Tier 3: \$140 copay Tier 4 Specialty: Not eligible for 90 day supply (in-network only)	Tier 1a: \$20 copay Tier 1b: \$40 copay Tier 2: \$90 copay Tier 3: \$140 copay Tier 4 Specialty: Not eligible for 90 day supply (in-network only)	Tier 1a: \$20 copay Tier 1b: \$40 copay Tier 2: \$90 copay Tier 3: \$140 copay Tier 4 Specialty: Not eligible for 90 day supply (in-network only)	Tier 1a: \$20 copay Tier 1b: \$40 copay Tier 2: \$90 copay Tier 3: \$140 copay Tier 4 Specialty: Not eligible for 90 day supply (in-network only)

This is an overview of your benefits. For more detailed information please contact your benefits administrator or ask us for a copy of the Certificate of Coverage for your health plan. If there are discrepancies between this benefit overview and the Certificate of Coverage, the Certificate will govern.

Revised: 1/22/2026